

6. PLEASE GIVE YOUR WEIGHT: _____ YOUR HEIGHT: _____
7. DO YOU CURRENTLY SMOKE CIGARETTES/CIGARS? YES NO IF YES, HOW MANY PER DAY? _____
- 7a. DID YOU SMOKE CIGARETTES/CIGARS IN THE PAST? YES NO IF YES, WHEN DID YOU QUIT ? _____
- b. HOW LONG DID YOU SMOKE? _____
8. DO YOU DRINK ALCOHOL DAILY? YES NO IF YES, HOW MUCH? _____

9. DO YOU HAVE ANY LOOSE, BROKEN OR CAPPED TEETH? YES NO
IF YES, PLEASE CIRCLE: LOOSE BROKEN CAPPED
10. DO YOU WEAR (a) DENTURES? YES NO
(b) CONTACT LENSES OR GLASSES? YES NO
(c) A HEARING AID? YES NO
(d) A PROSTHESIS? YES NO IF YES, PLEASE SPECIFY _____

11. LIST ALL PREVIOUS SURGERIES; INCLUDING DATES:

12. HAVE YOU OR ANY MEMBER OF YOUR FAMILY HAD ANY PROBLEMS CONNECTED WITH ANESTHESIA OR OPERATIONS, SUCH AS MALIGNANT HYPERTHERMIA? YES NO
IF YES, PLEASE SPECIFY INCLUDING WHEN, WHERE AND TYPE OF REACTION: _____

13. HAVE YOU BEEN HOSPITALIZED FOR ANY REASON IN THE PAST YEAR? YES NO
IF YES, PLEASE SPECIFY? _____

14. IT IS IMPORTANT THAT SOMEONE REMAIN AT WESTFALL SURGERY CENTER DURING THE PROCEDURE. WHO WILL BE PROVIDING TRANSPORTATION AND STAYING AT THE CENTER WITH YOU ON THE DAY OF YOUR SURGERY? _____

15. DO YOU HAVE SOMEONE AT HOME TO HELP YOU WITH YOUR CARE AFTER YOUR SURGERY? YES NO

16. DO YOU HAVE ANY CONCERNS OR SPECIAL PROBLEMS THAT WE SHOULD BE AWARE OF? YES NO
IF YES, PLEASE EXPLAIN: _____

17. DO YOU HAVE AN ADVANCE DIRECTIVE, THAT IS, A HEALTH CARE PROXY OR A LIVING WILL? YES NO
IF YES, WHICH? _____

(Please bring with you on the day of your procedure)

WESTFALL SURGERY CENTER HAS PACKETS OF INFORMATION ON ADVANCE DIRECTIVES READILY AVAILABLE FOR ALL PATIENTS.

DATE	SIGNATURE OF PATIENT OR RESPONSIBLE ADULT

FOR FEMALES

DATE OF LAST MENSTRUAL PERIOD _____ NA

ARE YOU PREGNANT OR SUSPECT THAT YOU MIGHT BE? YES NO

DO NOT WRITE BELOW THIS LINE

PATIENT HISTORY FORM
REVIEWED BY _____ RN DATE _____

COMMENTS: (If Appropriate) _____

DATE _____
SIGNATURE _____